CorHealth Ontario	RVH Royal Victoria	
CATH REFERRAL	Regional Health Centr	re de Pt Name:
DATE OF REQUEST (DOR):	-	re Pt Name:
	RTANT: Notify CATH centre of any change in the patient's co	ondition V Address:
PHYSICIAN DETAILS	Time	
NAME of Referring Physician	Type Specialist Family/GP	E E-mail Contact:
	Referring MD is out-of-provinc	ce G Home Phone #: Other Contact #:
NAME of GP/Family Physician (if different f	rom Referring) Date of Request for Specialist Cor	ce City/Town: Province: Postal Code: E-mail Contact: Home Phone #: Other Contact #:
NAME of Requested Procedural Physician(Date Format YYYY-MM-D	DD For Coordinator Use ONLY RMWT URS WAIT
	or 1st Available	Referral Date: - - Acceptance Date: - -
PRIMARY REASON FOR REFERRAL	SECONDARY REASON	Inpt Admit Date: Booking Date:
Coronary Disease (CAD)	Aortic Stenosis Heart Failure	Transfer Date: Discharge Date:
Stable CAD Unstable Angina	Echo valve area cm ² Congenital	Scheduling Details Date Format YYYY-MM-DD
	Echo gradient mmHg Arrhythmia Spe	
Other:	Other Valvular Cardiomyopathy	
Research Biopsy	Other Specify	MEDICAL DELAY – –
REQUEST TYPE Referral for CATH and consultation regarding subsequent management	No consult required – CATH only	FAX CATH Report to: Person/Organization:
URGENCY (estimate from Referring Ph	ysician) (select 1 only)	Fax Number: E-mail: SPECIAL INSTRUCTIONS and/or BRIEF HISTORY
Emergent Urgent (while still in ho	ospital) Urgent (within 2 wks) Elec	tive
		_
PATIENT WAIT LOCATION	spital: Specify	—
Home ICU/CCU Ward:	Specify Other: Specify	—
Translator Required? No	Language	Previous CATH done outside of Ontario
RECENT or PREVIOUS MI	CCS/AC	S ANGINA CLASS
History of MI No Yes 1-3 Months >3-6 Months >6-12 Months Recent MI No Yes Date: (Within 30 Days) No Yes Date:		CAD Acute Coronary Syndrome (ACS) I II III IV Low Risk (IV-A) Intermediate Risk (IV-B) High Risk (IV-C) Emergent (IV-D) High Risk (IV-C) Emergent value High Risk (IV-C) Hemodynamically unstable Hemodynomicopic or vasopressor or balloon pump)
HEART FAILURE CLASS (NYHA)	Date unknown COMORBIDITY ASSESSMENT	(i.e., requires interspices interspices in balloon painp)
I II III IV Not a	pplicable Creatinineµmol/L	Known Pending Not done
REST ECG Done Not	Dialysis t done Diabetes	No Yes → Diet Insulin Oral Hypoglycemics No Treatment
Ischemic changes at rest?	History of Smoking	Never Current Former Unknown
Type: Not applicable Persistent	Hypertension	
Transient w/ pain	nypernplaema	No Yes No Yes Unknown
EXERCISE ECG Done No	Peripheral Vascular Disease (PVD) ot done COPD	□ No □ Yes □ No □ Yes
Risk: Not applicable	Previous (CABG) Bypass Surgery	No Yes
Low High Uninterp	oretable LIMA Previous PCI	No Yes Prev CABG Date
FUNCTIONAL IMAGING Done	Not done Anticoagulant	
Risk: Low High Not app		Coumadin Heparin LMWH Dabigatran If Other
LV FUNCTION Done Not do Method:	one On IIb/IIIa Inhibitors Dye Allergy	No Yes Unknown
Other ECHO MUGA Ventr	iculogram Possible Intracardiac Thrombus	No Yes Unknown
Findings: I(>=50%) II(35-49%) III(20-34%)	IN(<20%)	No Yes Active Endocarditis No Yes
Not applicable	Congenital Heart Disease History of CHF	
LV Function Percentage: %	Ethnicity	White Aboriginal South Asian Asian Black Unknown
	i+ Months	Height cm Weight kg
OTHER FACTORS affecting prioritizat	ion PATIENT OPTIONS for Timely	
Other clinical factors Non-clinical f	factors MD SIGNATURE	sed with this patient (and/or significant others) timely access to care options for this procedure. Date (YYYY-MM-DD):
Electronic form and instructions available at: www.co		Form Revised August 22, 2017
